

PEDIATRIC & ADOLESCENT DERMATOLOGY: BEYOND ECZEMA, WARTS, AND ACNE

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Infant Skin Conditions



CASE 1

A 7 month-old girl is brought to your office by her mother for a 3-week history of a progressively worsening diaper rash despite using zinc-oxide. Mom denies any history of diarrhea in her daughter, although her 6 year-old son was recently diagnosed with strep throat. She recently stopped breast feeding a month ago. The baby is afebrile and is otherwise feeling well. What is the next best step?

- a. measure a serum zinc level
- b. culture the rectal area**
- c. prescribe clotrimazole
- d. prescribe a low potency topical steroid**
- e. b and d**



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Napkin Psoriasis

- Persistent eruption in the diaper area that fails to respond to topical anti-yeast and barrier preparations
- Typically well-demarcated
- Silvery scale
- Look for other classic lesions
- **Work-up:** Culture for perianal *Streptococcus*
- **Treatment:** low dose corticosteroids, calcipotriene

CASE 2

An 13 month-old boy was recently brought to your clinic for a physical examination. He recently immigrated here from Guatemala with his mother and two older sisters. You notice several firm, pedunculated papules on the right cheek extending down from the ear. What is the next step in management?

- a. order a hearing test
- b. order a renal ultrasound
- c. check for café au lait macules
- d. do nothing, these are benign skin tags
- e. a and b



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Accessory Tragus

- Relatively-common benign congenital anomaly
 - occur as frequently as in 1 to 2 births per 1000
- **Ddx:** acrochordon (skin tag), branchial cyst, auricular fistula, epidermoid cyst, cutaneous cartilaginous rest
- Occasionally signal a defect in the first or second branchial arches
 - cleft lip, cleft palate, or hypoplasia of the mandible; GU abnormalities
 - **the incidence of these malformations increases the closer the tragus is located to the mouth.**
- Associated conditions:
 - **Goldenhar Syndrome** (Oculoauriculovertebral dysplasia): AR, phenotypically variable syndrome consisting of malformations in the first and second branchial arches
 - **Treacher Collins Syndrome:** AD condition most often consisting of ocular defects, external ear malformations, and hypoplasia of the face.
- **Work-up:** renal ultrasound; hearing test
- **Treatment:** elliptical excision

CASE 3

A 20 month old boy is brought to the clinic for evaluation of his “moles”. His mother has a history of melanoma and she is concerned that her son is getting so many moles so early. She is especially concerned because they swell sometimes and are itchy. How do you counsel her?

- a. Tell her that this is an appropriate number of moles for his age.
- b. Agree with her; they are displaying atypical features and require biopsy.
- c. Counsel her that these lesions will resolve by puberty.
- d. Recommend digital mole mapping.



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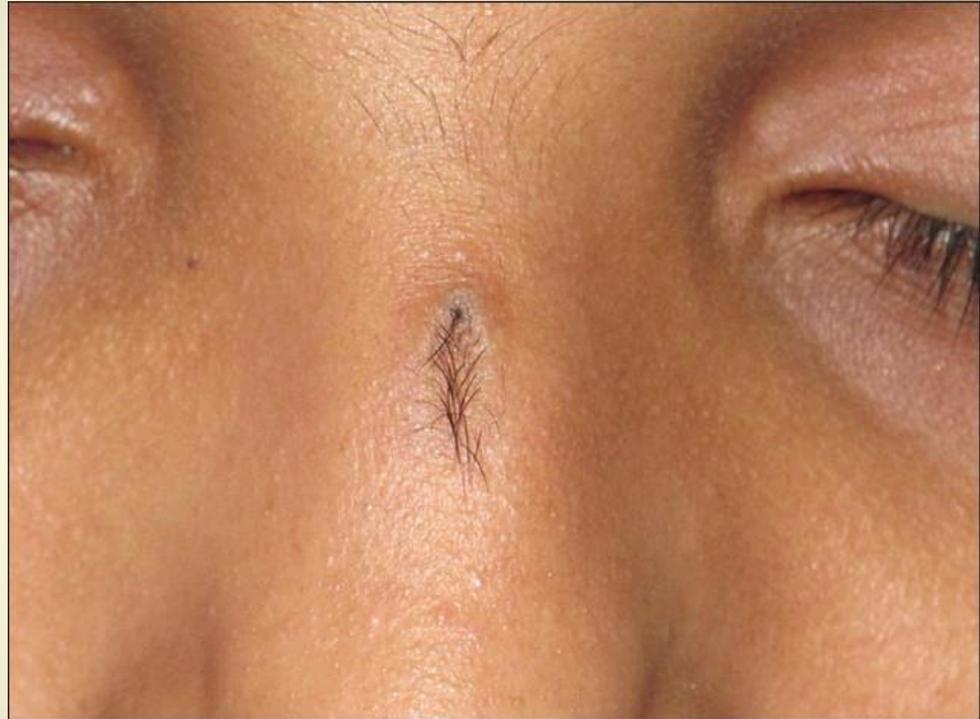
Urticaria Pigmentosa

- Mastocytosis: group of clinical disorders characterized by **accumulation of mast cells in the skin.**
- Urticaria pigmentosa-most common in children
 - **Urticaria Pigmentosa:** scattered foci of pink/brown papules demonstrating Darier's sign
 - **Solitary mastocytoma:** yellow-orange-brown urticating papule or plaque
 - **Diffuse cutaneous mastocytosis:** less common; diffuse infiltrate of the skin by mast cells.
 - urticaria, blistering, peau d'orange or thickened texture. Patients with this form have the highest rate of systemic disease: flushing, headache, abdominal pain, diarrhea, vomiting, rarely shock.
- Sporadic in children; c-kit mutations in adults
- 50% of cases present before age 2.
- Generally resolves by puberty
- **Treatment:** occlusive steroids, non-sedating H1-antihistamines, oral steroids, cyclosporine, interferon-2 α , PUVA, systemic mastocytoses with KIT K5091 germ line mutation responds to imatinib
- www.mastokids.org

CASE 4

A 5-week old baby presents with the following tuft of hair growing from the nasal bridge. The baby is otherwise healthy and was the product of a full-term vaginal birth. What is the next best step in management?

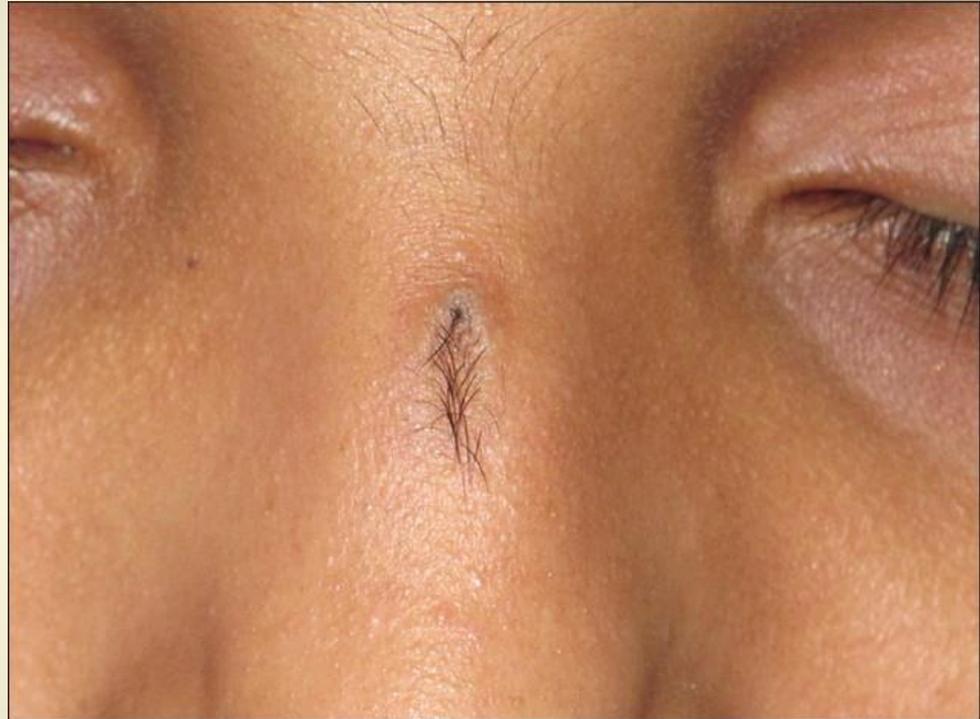
- a. MRI
- b. referral for laser hair removal
- c. biopsy
- d. check adrenal androgens



CASE 4

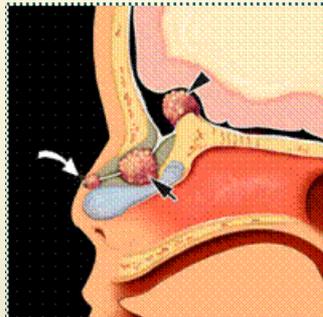
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Dermoid Cyst/Sinus

- Non-tender, mobile subcutaneous mass most commonly presenting on the brow ridge of neonates
- 3% are located in the nasal midline (glabella, nasal dorsum and columella)
- Overlying ostium with discharge or hairs sometimes present
- Potential for deep extension and CNS connection for midline location only



- **Ddx:**
 - Cephalocele-crying enlarges lesion; transilluminates
 - Glioma-firm, non-compressible nodule
 - Hemangioma-firm, non-compressible, blue hue
- **Treatment:** MRI; neurosurgery/plastics evaluation

COMMON SITES OF DEVELOPMENTAL ANOMALIES OF THE FACE AND NECK

★ Dermoid cysts (skin-colored, firm, +/- sinus ostium and hair)

+ Nasal gliomas (red, firm, non-compressible)

■ Encephaloceles (blue, soft, compressible; may transilluminate)

▲ Lip pits

✕ Midline cervical clefts

● Thyroglossal duct cysts (often move with swallowing or protrusion of the tongue)

● Bronchogenic cysts

★ Sternal clefts

● Ear pits

✕ Accessory tragi/congenital cartilaginous rests of the neck

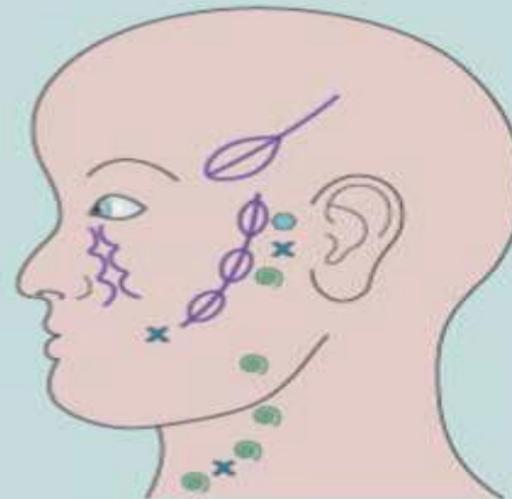
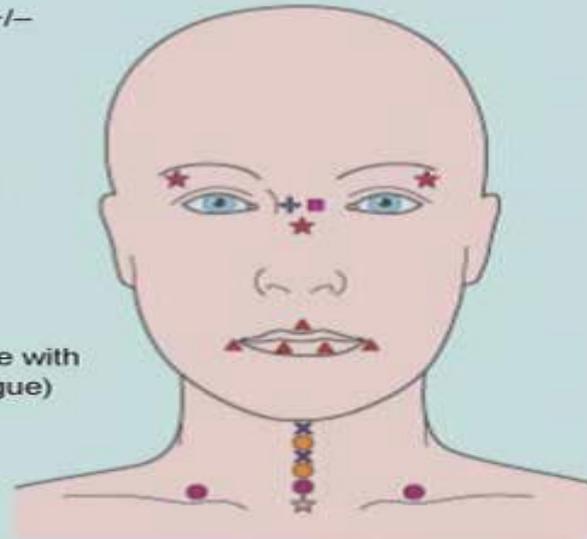
● Branchial cleft cysts

Facial aplasia cutis congenita (ACC)

A: Brauer lines/Settleis syndrome (membranous ACC along the embryonic fusion plane between the frontonasal and maxillary prominences)

B: Preauricular membranous ACC (along the embryonic fusion plane between the maxillary and mandibular prominences)

C: Microphthalmia with linear skin defects syndrome (irregular, stellate ACC; also may involve neck)



CASE 5

A 4-month old girl is brought to your office for management of her atopic dermatitis. On inspection, the patient displays fine 1-2 mm bright red papulovesicles on her face, chest and the anterior aspects of her extremities. What is the most likely cause for this infant's flare?

- a. contact dermatitis
- b. candidiasis
- c. impetiginization
- d. food intolerance



CASE 5

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Allergic Contact Dermatitis: Lanolin in Aquaphor®

- Type IV delayed-type hypersensitivity reaction
- **Contact Allergen of the Year 2014: Benzophenone**-strong UVB blocking sunscreen
- **Contact Allergen of the Year 2013: Methylchloroisothiazolinone**-Eucerin®, Tide®, babywipes
- **Nickel** (nickel sulfate hexahydrate)-metal frequently encountered in jewelry and clasps or buttons on clothing
 - Foods (oatmeal, cereals, legumes, canned goods, metal pots and pans); Essure® implantable contraceptive device
- **Gold** (gold sodium thiosulfate)-precious metal often found in jewelry
 - Commonly cross-reacts with copper and nickel
- **Balsam of Peru** (myroxylon pereirae)-a fragrance used in perfumes
 - Vanilla, clove, cinnamon, cola, tomato, oranges, menthol
- **Thimerosal**-a mercury compound used in local antiseptics and in vaccines
 - Removing amalgam fillings has led to improvement in adult patients with Atopic Dermatitis
- **Neomycin sulfate**-antibiotic creams, ointments, cosmetics, deodorant, soap
- **Fragrance mix**-a group of the eight most common fragrance allergens
- **Formaldehyde**-a preservative with multiple uses, e.g., in paper products, paints, medications, household cleaners, cosmetic products and fabric finishes
 - Coffee, tofu, maple syrup, shiitake mushrooms, smoked ham
- **Cobalt chloride**-metal found in medical products; hair dye; antiperspirant; objects plated in metal such as snaps, buttons or tools; and in cobalt blue pigment
 - Flax seeds, green leafy vegetables, oysters
- **Bacitracin** -- a topical antibiotic
- **Quaternium 15** -- preservative found in cosmetic products such as self-tanners, shampoo, nail polish and sunscreen or in industrial products such as polishes, paints and waxes

CASE 6

A 7-month old boy is brought to your office with this pruritic pustular eruption. It is his third episode since 2 months of age. Anti-scabietic therapies have been ineffective. A scraping of the lesions reveals dense neutrophils but no mites. Cultures have been negative. What's the diagnosis?

- a. Scabies
- b. Impetigo
- c. Psoriasis
- d. Acropustulosis of Infancy



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- a. Scabies
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Acropustulosis of Infancy

- Crops of pruritic vesiculopustules on the palms and soles that recur every few weeks to months. Pinpoint papules enlarge into discrete pustules
- Ddx: scabies, dyshidrotic eczema, pustular psoriasis, impetigo
- Scraping reveals numerous neutrophils
- Unclear etiology; possibly a persistent immune reaction to prior scabies infection
- Flares become less intense over time subsiding at 2-3 years of age
- **Treatment:** topical permethrin (initially), topical corticosteroids, oral antihistamines

CASE 7

A 2-month old girl presents to the office with her mother for numerous annular plaques with indurated borders. They don't appear to be pruritic. The rest of the examination reveals a slightly irregular heartbeat. They have no pets. The baby has had no sick contacts. What's the diagnosis?

- a. Tinea faciei
- b. Lupus
- c. Disseminated Lyme
- d. Erythema marginatum



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Neonatal Lupus

- Variant of lupus found in infants born to mothers with SLE, RA, MCTD, Sjogren's syndrome
- Due to transplacental passage of Ro-antibody
- 16% of Ro+ mother's have babies with NLE
- Sun-exposed areas: annular lesions, "raccoon eyes", mucosal erosions
- Average age of onset 6 weeks; 1/4 babies present at birth
- May establish a previously unknown diagnosis in the mom
- Risks:
 - congenital heart block in 15-30%
 - inflammation and calcification of the AV>SA node
 - usually irreversible
 - majority have 3rd degree block; 2/3 require pacemakers
 - 20% mortality
 - U1-RNP Ab no associated cardiac issues
- Hepatomegaly; splenomegaly; thrombocytopenia; anemia
- Skin lesions clear by a year
- Work-up: CBC, LFTs, EKG, serologies
- **Treatment:** supportive +/- pacemaker

CASE 8

A 2-month old boy comes to the office with his mom for a well-child visit. Mom is concerned about his patch of hairloss on the left side of his scalp. How do you counsel her?

- a. Plan to have the lesion removed surgically, as it may become malignant.
- b. Tell her that he has alopecia areata and that it will grow back.
- c. Tell her that it may have been from the forceps delivery and may grow back.
- d. Tell her that it is a birthmark and nothing to worry about.



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Nevus Sebaceus

- Fairly common, hairless yellow-tan, flat congenital plaque occurring on the scalp and face
- The surface may be smooth, becoming verrucous or velvety over time.
- Hamartoma
 - normal tissue in an abnormal place: epidermal acanthosis, sebaceous glands, apocrine glands and absence of hair.
- **Malignant degeneration can occur: Basal Cell Carcinoma**
 - New papule, nodule or pigmented papule
- **Treatment:** excision
 - after 6 months of age but before school age

School-Age Skin Conditions



CASE 9

A 9-year old boy comes to the office for the abrupt onset of this widespread eruption. He otherwise feels well and is afebrile. He reports only slight itch despite the irritating appearance of the rash. What is the next best step in management?

- a. Do a biopsy for vasculitis. It looks like HSP.
- b. Tell mom to keep him out of school; he has chicken pox.
- c. Prescribe doxycycline. This is a bad case of folliculitis.
- d. Prescribe erythromycin for 3 months. That should take care of it.



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Pityriasis Lichenoides et Varioliformis Acuta “PLEVA”

- Recurrent, **asymptomatic** crops of pink-red /brown papules with telangiectasias, vesicles, pustules, ulcers and crusting.
- Peak onset 5 years. M>F
- Seasonal presentation: Spring or Fall
- Range of duration:1-48 months, mean 11.
- **Associated with recent URI**, Epstein-Barr virus, HIV, recent vaccination
- **Ddx:** Varicella, small vessel vasculitis/Henoch-Schonlein purpura, drug eruption, arthropod assault
- **Treatment:** topical steroids, oral erythromycin 30-50 mg/kg divided tid, phototherapy or methotrexate (resistant cases)

Hapa A, Ersoy-Evans S, Karaduman A. **Childhood pityriasis lichenoides and oral erythromycin.** Pediatr Dermatol. 2012 Nov-Dec;29(6):719-24. 2012 May 29.

CASE 10

A 6-year old girl is brought into your office by her dad for this rash that just appeared over the weekend. She had a soccer game on Saturday. The family went for a hike to the Hublein Tower on Sunday. She denies any itch. On exam you feel a mildly enlarged lymph node in the neck. What do you prescribe for her?

- a. Hydrocortisone, if anything.
- b. Triamcinolone for no more than a week.
- c. Amoxicillin tid for 3 weeks.
- d. Ketoconazole cream bid x 2 weeks.



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Unilateral Laterothoracic Exanthem (Asymmetrical Periflexural Exanthem of Childhood)

- Mildly pruritic, papular-urticarial self-limited eruption associated with antecedent URI
- Unilateral, axillary>inguinal “Statue of Liberty” sign →becomes bilateral; extinguishes in 6-8 weeks
- Caucasian children 1-5 years of age in the winter and spring. F>M
- **Ddx:** contact dermatitis, inverse pityriasis rosea
- Associated viruses: adenovirus, parainfluenza virus, parvovirus B19, human herpes virus (HHV)-6 and HHV-7, and Epstein–Barr virus
- **Treatment:** symptomatic (mild topical steroids)

CASE 11

A 9-year old boy comes to your office with his dad for a fever. The patient has not been feeling well for the past 2 days and has had fever both days. He just came back from a soccer sleep-over camp over the weekend. He reports his hands feel stiff. Upon exam, you see swollen digits and pink/erythematous papules and plaques on the palm. A strep test is negative. What is the diagnosis?

- Strep pharyngitis.
- Juvenile Idiopathic Arthritis
- Parvovirus infection
- Erythema multiforme



CASE 11

A 9-year old boy comes to your office with his dad for a fever. The patient has not been feeling well for the past 2 days and has had fever both days. He just came back from a soccer sleep-over camp over the weekend. He reports his hands feel still. Upon exam, you see swollen digits and pink/erythematous papules and plaques on the palm. A strep test is negative. What is the diagnosis?

- a. Strep pharyngitis.
- b. Juvenile Idiopathic Arthritis
- c. Parvovirus infection
- d. Erythema multiforme



Justin Finch, MD

Papular Purpuric Gloves and Socks

- Rapidly progressive, symmetric swelling and erythema of the hands and feet with often a petechial or purpuric component
- Hyperemia, petechiae and erosions of the oral mucosa is often present
- Most commonly caused by Parvovirus B19
- **Patients are viremic in this phase**
- **Treatment:** self-limited supportive
- Fifth's Disease-"Erythema Infectiosum"
- Transmitted by respiratory droplet and followed by viremia lasting 5-7 days with headache, fever and chills and production of IgM
- **Production of IgG after the third week is coincident with the "slapped cheek" rash and arthralgias = not infectious**
- Stage 2 consists of a lacy reticulated rash 1-4 days after the facial rash
- Stage 3 represents the waxing and waning of stage 2
 - Sunlight, hot bath

CASE 12

A 7-year old boy is brought into your office by his mom for a rash that mom reports has been spreading down his arm. They just came back from a vacation in Puerto Rico and mom is concerned that her son has caught some “tropical disease”. On exam you see a linear array of slightly scaly, monomorphic pink papules.

What is the most likely diagnosis?

- a. Phytophoto reaction, from squeezing limes into their limonada.
- b. Cutaneous larva migrans, from lying on the beach.
- c. Shingles.
- d. Lichen striatus.



CASE 12

A 7-year old boy is brought into your office by his mom for a rash that mom reports has been spreading down his arm. They just came back from a vacation in Puerto Rico and mom is concerned that her son has caught some “tropical disease”. On exam you see a linear array of slightly scaly, monomorphic pink papules.

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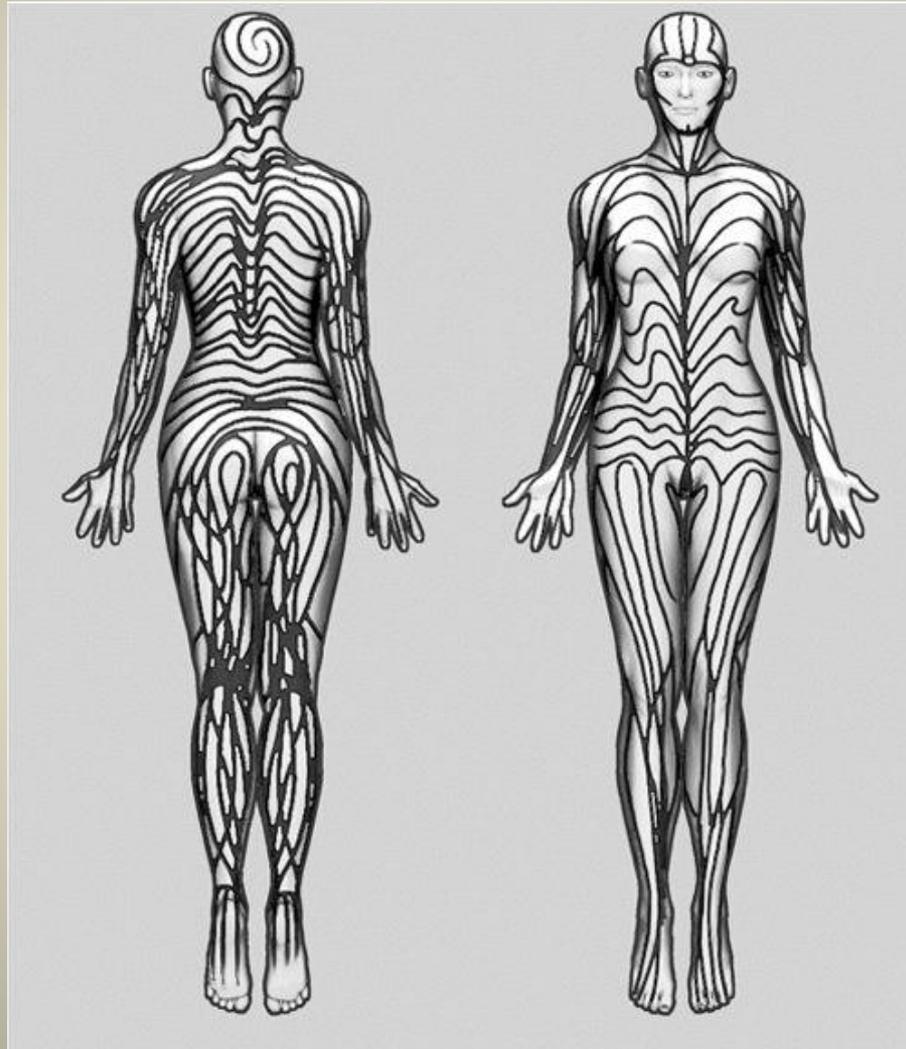
d. Lichen striatus.



Lichen Striatus

- Curvilinear band composed of discrete 1-2mm flat-topped papules
- Follows the lines of Blaschko.
- Self-limited eruption
- F>M
- May be slightly scaly or hypopigmented in dark-skinned children
- Extremity>face>trunk
- **Ddx:** linear verrucous epidermal nevus, linear lichen planus, linear psoriasis, linear verrucae
- **Treatment:** self-limiting (3-36 months); topical steroids

Blaschko's Lines: Embryonic migration path of skin cells.



CASE 13

A 5-year old boy is brought into the office for a follow-up from a bad cold he had a month earlier. Mom is concerned because she states for the past 2 days these spots just keep popping up. He has been sleeping with the cat since he was sick and mom thinks he might have an allergy. On exam, you see numerous edematous, monomorphic papules on the upper and lower extremities. The trunk is seemingly spared. What do you advise the mom to do.

- a. Nothing. They spots should be gone in a week.
- b. Nothing. They should be gone in 8 weeks.
- c. Put the cat outside.
- d. Change the laundry detergent.



CASE 13

A 5-year old boy is brought into the office for a follow-up from a bad cold he had a month earlier. Mom is concerned because she states for the past 2 days these spots just keep popping up. He has been sleeping with the cat since he was sick and mom thinks he might have an allergy. On exam, you see numerous edematous, monomorphic papules on the upper and lower extremities. The trunk is seemingly spared. What do you advise the mom to do.

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- b. Nothing. They should be gone in 8 weeks.
- c. Put the cat outside.
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Gianotti-Crosti

- **Asymptomatic**, edematous, erythematous, monomorphic papules distributed symmetrically over face, extensor upper and lower extremities, **sparing the trunk**
- Age 1-6
- Viral etiology
 - **Hepatitis B**-specifically, ayw surface protein
 - **Most common in US: Epstein-Barr Virus**>CMV, Coxsackie, Adenovirus, RSV, Parvovirus, HHV-6
- **Work-up:** Routine LFTs or Hep serologies in clinically suspicious cases only
- **Treatment:** Self-limited, 8-12 wks

Adolescent Skin Conditions



CASE 14

A 17-year old boy is brought to your office by his mom for his horribly smelly feet. She states that “there must be something wrong...he ‘lives’ in his work boots...who knows what’s growing inside them!” On exam you see a large crateriform erosion on the ball of his right foot. There are similar findings on his other foot. What is your diagnosis?

- a. Bullous tinea infection.
- b. Pseudomonas infection.
- c. Trench Foot.
- d. Corynebacterium infection.



CASE 14

A 17-year old boy is brought to your office by his mom for his horribly smelly feet. She states that “there must be something wrong...he ‘lives’ in his work boots...who knows what’s growing inside them!” On exam you see a large crateriform erosion on the ball of his right foot. There are similar findings on his other foot. What is your diagnosis?

- a. Bullous tinea infection.
- b. Pseudomonas infection.
- c. Trench Foot.
- d. *Corynebacterium* infection.



Pitted Keratolysis

- Shallow round pits and crateriform erosions on the weight-bearing aspects of the feet
- Malodor is common
- Caused by *Corynebacterium (Kytococcus) sedentarius*
- Common in hot climates, boot-wearers
- **Work-up:** Gram stain of stratum corneum shavings
- **Treatment:** Topical clindamycin 1% gel bid

CASE 15

A 14-year old African-American girl comes to your office concerned about the white patches on her back. She tried Selsun Blue® that her friend recommended, but it has not helped. She is concerned that she will “turn out like Michael Jackson” so wants them “fixed fast.” On exam, you notice a very subtle hypopigmented eruption on the back. Wood’s lamp examination reveals perifollicular fluorescence. What’s the dx?



- a. Vitiligo
- b. Progressive Macular Hypomelanosis
- c. Tinea versicolor
- d. Idiopathic Guttate Hypomelanosis

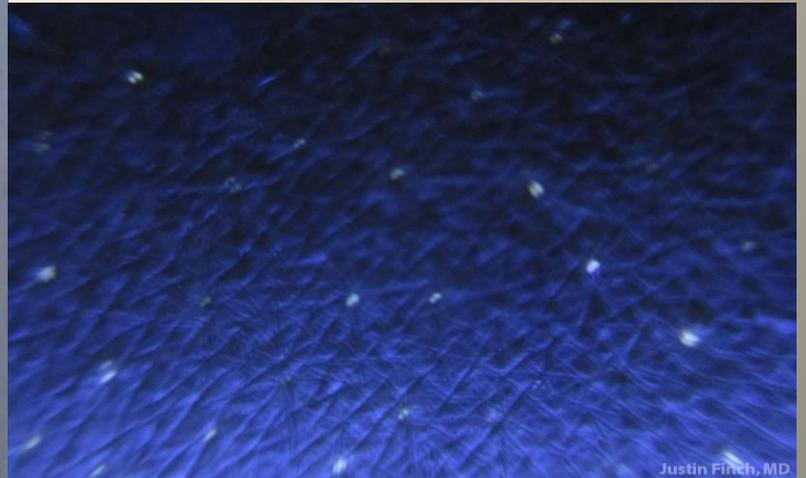


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- a. Vitiligo
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- c. Tinea versicolor
- d. Idiopathic Guttate Hypomelanosis



Progressive Macular Hypomelanosis

- Commonly misdiagnosed skin condition
- Hypopigmented macules on the trunk, often confluent in and around the midline, and rarely extending to the proximal extremities and neck/head
- Dark-skinned patients > Caucasian; F > M
- **Propionibacterium acnes-associated**
- Stable disease or perhaps slow progression over decades, with spontaneous disappearance after mid-life
- Shift from large melanosomes in normal-looking skin to small aggregated, membrane-bound melanosomes in hypopigmented skin
- **Work-up:** wood's lamp examination
- **Treatment:** 1% clindamycin lotion during the daytime, 5% benzoyl peroxide gel at night-time, and UVA light irradiation three times a week for a period of 12 weeks.

CASE 16

A 16-year old boy is brought to your office by his dad for a rash on his back. Dad reports that it started during football season on the chest and it just keeps spreading. His dad also remarks that he has a similar eruption. The boy is slightly large for his age, had one febrile seizure at age 5, but has no other significant medical history. There is a family history of Type II diabetes. On exam you see small, 2-mm brown papules coalescing into a large plaque on the back. KOH-negative.

What is your diagnosis?

- a. Darier's Disease
- b. Hyperpigmented T. versicolor
- c. Confluent and Reticulated

Papillomatosis

- d. Acanthosis Nigricans



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What is your diagnosis?

- a. Darier's Disease
- b. Hyperpigmented T. versicolor
- c. Confluent and Reticulated Papillomatosis
- d. Acanthosis Nigricans



Confluent & Reticulated Papillomatosis of Gougerot and Carteaud “CARP”

- Velvety/Verrucous hyperpigmented discrete and confluent reticulated papules
- **Ddx:** Tinea versicolor; Acanthosis nigricans.
- Adolescents, shortly after puberty; range 5-63 years; M=F
- Postulated causes:
 - Disorder of keratinization
 - Reaction to Pityrosporum,
 - Eruption related to an endocrinopathy (insulin resistance)
 - Reaction to bacterial infection—Corynebacterineae Actinomycetales
- **Treatment:**
 - Minocycline 50-100mg bid x 6 weeks
 - Azithromycin 250-500mg tiw x 6 weeks
 - Creams: ketoconazole, tretinoin, calcipotriene

CASE 17

A 14-year old boy is brought to the office for a painful spot on the right cheek. He has just started high school, joined the wrestling team and has a new girlfriend. Life has been good except for the past week when he noticed this lesion. He has been out of school for the past 2 days also for low-grade fevers. On exam, he is clammy to the touch. A 1.2-cm plaque with central erosion is seen on the right cheek. He has a swollen, tender posterior cervical node. What's the diagnosis?

- a. Epstein-Barr virus infection
- b. HSV-1
- c. Giant molluscum
- d. Impetigo



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Herpes Gladiatorum

- Edematous plaque, vesicle or bulla from direct HSV inoculation (herpes labialis) occurring in contact sportsman (wrestlers, rugby players)
- Face/Neck > Lesions may be widespread
- Patients may have fever, sore throat, lymphadenopathy
- **Ddx:** tinea corporis, impetigo, molluscum
- **Work-up:** Direct fluorescent antibody; viral cx
- **Treatment:** Valtrex 1 g bid x 7 days

CASE 18

A 16-year old girl is brought to the ED by her mom for bleeding erosions on the bilateral arms. Mom reports that they began appearing after she started her junior year. The family had just moved to a new apartment that was recently treated for bed bug infestation. Mom is concerned that the bed bugs are back since these only appear the next morning. The only other change is a new cat. What is the next best step in management?

- a. Give mom the number for local exterminators.
- b. De-claw the cat.
- c. Prescribe clobetasol ointment for poison ivy.
- d. Make a referral to psychiatry.



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Dermatitis Artefacta (Factitial Dermatitis)

- Self-inflicted linear or other geometric wounds. Lesions typically manifest as erosions or ulcers with “well-debrided” edges.
- Triggering factors are frequently psychiatric disorders or specific stress situations.
- Establishment of the diagnosis is often time-consuming and complicated.
- **Early interdisciplinary cooperation is necessary.**
- Treatment:
 - Topical/oral antimicrobials
 - SSRIs (paroxetine, sertraline, citalopram, and fluoxetine)
 - TCAs (doxepin and amitriptyline)
 - Atypical Antipsychotics (risperidone, olanzapine, and quetiapine)

Summary

- Infantile dermatoses:
 - Consider congenital growths and malformations
 - Accessory tragus, Urticaria Pigmentosa, Dermoid Cyst, Nevus Sebaceus
- School-aged dermatoses:
 - Consider viral-associated exanthems
 - PLEVA, Ulilateral Laterothoracic Exanthem, Purpuric Gloves and Socks [lacy reticulated exanthem], Gianotti-Crosti
 - Typically non-pruritic
- Adolescent dermatoses:
 - Consider bacterial, yeast and viral infections



THANK YOU